2022 Retiree Benefits Form ***University Health Services Inc.***

Please Print Clearly in Blue or Black Ink

Employee Last Name:	First Name:	MI	Date of Birth:
Phone Number:	Email Address:	❑ Male ❑Female	Social Security #:
Street Address:	City:	State:	Zip:
Effective Date:	Reason for Change	Enrollment❑	Change❑

Dependent Information: List all dependents below that you are enrolling. Use additional page if needed. You must provide documentation when adding dependents to benefits (marriage license, birth certificates, etc.)

❑Spouse	Last Name:	First:	MI:	SS#:	DOB:	❑Male ❑Female
❑Medical ❑Dental ❑Vision						
❑Child	Last Name:	First:	MI:	SS#:	DOB:	❑Male ❑Female
❑Medical ❑Dental ❑Vision						
❑Child	Last Name:	First:	MI:	SS#:	DOB:	❑Male ❑Female
❑Medical ❑Dental ❑Vision						
❑Child	Last Name:	First:	MI:	SS#:	DOB:	❑Male ❑Female
❑Medical ❑Dental ❑Vision						

These are monthly premiums for the following benefits. Current benefit elections are noted with an *

Humana EyeMed Vision

	High	Low
Retiree	$9.38___	$6.70___
Retiree and Spouse	$17.84___	$12.74___
Retiree and Child(ren)	$18.76___	$13.40___
Retiree and Family	$27.57___	$19.69___
No Coverage		

United Concordia

	High	Low
Retiree	$51.80___	$28.62___
Retiree + Family	$103.56___	$41.58___
No Coverage ____		

I hereby authorize hospitals, physicians, dentists, or other providers of service to furnish to Meritain, United Concordia and Humana, or its agents, upon request, any and all reports, records, or copies thereof concerning any illness, injury, or condition for which service was provided to me or my dependents together with like reports, records, or copies thereof of all earlier services.

Emergency Contact Name: _____ Phone: _____

Retiree Signature: Sign, date, and return this form to Head Capital Advisors to implement the above enrollment/changes.

Retiree Signature: _____ **Date**_____

Exhibit D

UNIVERSITY
HEALTH CARE SYSTEM
Human Resources

Confirmation of Retirement

I _____ have met with the benefits team with University Hospital and have given notice that my last day as an active employee will be _____.

☐ In order to be eligible for retiree benefits and/or Medicare Advantage plan, I acknowledge that I am 60 years of age or older and have at least 20 to 30 **consecutive** years of service with University Hospital.

☐ I acknowledge that retiree benefits are effective the first of the month following my last day as an active employee.

☐ I acknowledge if I decide to change my last day as an active employee I must notify the following of the new date of retirement and complete another Confirmation of Retirement form:

- Benefits
- Carla James at Head Capital Advisors (706-733-5501)
- My manager or supervisor

☐ I acknowledge that by failing to notify the above named, my benefits with University Hospital will be terminated and the retiree benefits will begin effective the first of the month following my last day as an active employee.

☐ I acknowledge I must notify Benefits if I desire to Port or Convert any life insurance coverage for myself or dependents. I understand that any coverage I elect to continue after retirement will be a direct policy with Cigna.

_____ _____
Signature of Employee Date

_____
Employee ID number

1350 Walton Way, Augusta, GA 30901 ** 706-774-7169 ** Fax 706-774-89778/26/2019